Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:00 a.m. on June 9, 2004, and 8:00 a.m. on June 10, 2004, 9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

Edward J. Schwager, M.D., Chair
Sharon B. Megdal, Ph.D., Vice Chair
Robert P. Goldfarb, M.D., Secretary
Patrick N. Connell, M.D.
Ingrid E. Haas, M.D.
Tim B. Hunter, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Douglas D. Lee, M.D.
William R. Martin III, M.D.
Dona Pardo, Ph.D., R.N.
Chris Wertheim

Board Counsel

Christine Cassetta, Assistant Attorney General

Staff

Barry A. Cassidy, Ph.D., P.A.-C, Executive Director
Barbara Kane, Assistant Director
Beatriz Garcia Stamps, M.D., M.B.A., Board Medical Director
Gary Oglesby, Chief Information Officer
Tina Speight, Public Affairs Coordinator

WEDNESDAY, JUNE 9, 2004

CALL TO ORDER

Edward J. Schwager, M.D., Chair, called the meeting to order at 9:04 a.m.

ROLL CALL

The following Board members were present: Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board member arrived at 9:30 a.m.: Patrick N. Connell, M.D. The following Board member was absent from the meeting: Tim B. Hunter, M.D.

CALL TO THE PUBLIC

Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-03-0421A	O.G.	CLARE A. COLUMBO, M.D.	25810	Advisory Letter for failure to identify a foreign body on an x-ray. A.R.S. § 32-1401(3)(b) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Clare A. Columbo, M.D., appeared before the Board with her attorney Paul J. Giancola.

FORMAL INTERVIEWS (Continued) - CLARE A. COLUMBO, M.D.

Rudolf Kirschner, M.D., Board Medical Consultant, reviewed this case with the Board. The allegation is that Dr. Columbo failed to properly diagnose an obvious foreign body in the patient's right hand on an x-ray.

Clare A. Columbo, M.D., made a statement to the Board. She explained the process she uses when she reads x-rays. She stated that she missed the obvious foreign body in the patient's hand. Dr. Columbo stated no one informed her why the x-ray was taken of the patient's hand. She is rarely given the history of a patient. She now checks the soft tissue more thoroughly.

Ram R. Krishna, M.D., presenting Board member, began the questioning of Dr. Columbo. Dr. Columbo informed Dr. Krishna that a requisition was included with the patient's paperwork. Dr. Columbo stated that the history is rarely given to her in the requisition. She explained if there were a history included in the requisition, of a knuckle injury, she would have paid particular attention to it. Dr. Krishna pointed out that Dr. Columbo's x-ray report indicated that the soft tissue looked normal. Dr. Columbo clarified the report stated there was "no evidence" of a dislocation or foreign body, which was a mistake. She only mentions soft tissue, specifically, in her reports unless it is abnormal. The Board members began questioning Dr. Columbo. William R. Martin, III, M.D., clarified with Dr. Columbo that the report was dictated by Dr. Columbo and came from the Department of Radiology. Dr. Martin stated that the report states diagnosis read, three views of the right hand, clinical indication trauma, and the patient hit a glass. He clarified that Dr. Columbo had this information and was aware of it at the time she read the patient's x-rays. Robert P. Goldfarb, M.D., confirmed with Dr. Columbo that the only part of the report that she dictated was clinical indication. Edward J. Schwager, M.D., reiterated that after she reviewed the film later, she saw the foreign body. She stated that when she reviewed the x-rays initially, she looked at the wrist and the hand, but not the knuckle.

Mr. Giancola made a statement to the Board on behalf of Dr. Columbo. The circumstances are different than if a patient was in the office setting and the radiologist was able to have the history. Also, Dr. Columbo did not have the luxury of time. The E.R. physician and Physician Assistant (P.A.) signed off the initial read, which indicated that the x-ray was negative. Mr. Giancola stated that the patient would have had to go back to get the glass removed regardless. There was a note from the physician to follow up within two-three days, but the patient did not follow up as instructed. When the patient did return, he had the glass removed. The records showed no indication of infection or change in condition.

Ram R. Krishna, M.D., commented that he appreciated Dr. Columbo's honesty. He was concerned about the P.A., who also missed the foreign body in the x-ray and the patient was sent home. If a patient has any foreign body, in the middle of the night, they are usually sent home and brought back to a specialist to have it removed if it is deep seated. There was no neurovascular laceration. There was a delay in the treatment of this patient, but there was no negative outcome. Although, there was some inconvenience to the patient. It is obvious that Dr. Columbo missed the foreign body, but no reason for disciplinary action, because there was no patient harm done. Therefore, Dr. Krishna stated that this does not rise to the level of discipline.

MOTION: Sharon B. Megdal, Ph.D., moved to issue an Advisory Letter for failure to identify a foreign body on an x-ray. A.R.S. § 32-1401(3)(b) - The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board members were absent from the meeting: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NON-TIME SPECIFIC ITEMS

Rational Recovery and other Programs

David Greenberg, M.D., and Michael Sucher, M.D., Monitored Aftercare Program (MAP) Consultants, made a presentation to the Board regarding "Rational Recovery and other Programs." Dr. Greenberg explained the difference between chemical dependency and substance abuse. This impacts the types of therapies used. An abuse pattern is an individual who drinks or uses drugs, but can stop or moderate when they get in trouble. Those who are chemically dependent cannot stop, even when bad things or consequences happen to them. After investigating both the Rational Recovery and Smart Recovery programs, Drs. Greenberg and Sucher reviewed them with the Diversion Committee. They felt that they were not an acceptable mode of monitoring or aftercare treatment for the Board's MAP participants at this time. Edward J. Schwager, M.D., stated that the Board received a memo from the Attorney General's Office about this topic and recommended that the Board members go into executive session for discussion.

MOTION: Sharon B. Megdal, Ph.D., moved to go into executive session at 11:30 a.m.
SECONDED: Ram R. Krishna, M.D.

NON-TIME SPECIFIC ITEMS (Continued) – Rational Recovery and other Programs
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board returned from executive session at 11:48 a.m.

Patrick N. Connell, M.D., stated that based on the evidence heard, there is not sufficient information for the Board to support or fully endorse the Rational Recovery or Smart Recovery programs. He stated that the Board could reconsider an alternate program that could be presented to the Board with convincing data of relapse or success rates that are equivalent to the Alcoholics Anonymous (AA) based programs. Until then, he recommended allowing participants of the MAP program to use one of these alternative recovery programs for one of their three meetings per week and leave the Board's standards the same.

MOTION: Patrick N. Connell, M.D., moved to not fully endorse the Rational Recovery or Smart Recovery programs, but allow MAP participants to use one of these alternative recovery programs for one of their three meetings per week and leave the Board's standards the same.
SECONDED: Sharon B. Megdal, Ph.D.

Sharon B. Megdal, Ph.D., stated that the real problem is that the Board members were not presented with a track record of the success of these programs. She stated that the Board would be open to receiving further information in the future to consider an alternative treatment or program that could be approved. Dr. Megdal agrees with the motion as stated.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
34.	MD-03-0826A	AMB	MARTIN L. MEYERS, M.D.	27917	Letter of Reprimand for violating a Board Order. Defined Terms for Vacating Practice Restriction

Dona Pardo, Ph.D., R.N., confirmed with Christine Cassetta, Board Legal Advisor, that the date needs to be changed from 2004 to 2003 on page 3, lines 3 and 5 of the draft order.

MOTION: Robert P. Goldfarb, M.D., moved to approve the draft Findings of Fact, Conclusions of Law, and Order with the corrections as stated above.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board member was absent when this matter was considered: Sharon B. Megdal, Ph.D. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

Terms for vacating Practice Restriction:
Edward J. Schwager, M.D., reiterated that Dr. Meyers is currently under restriction to not practice, because of the initial Order and the need for an evaluation. Michael Sucher, Monitored Aftercare Program (MAP) Consultant, reviewed this case with the Board. He stated that last summer, Dr. Meyers was found to be in relapse with the use of Nubain. Dr. Sucher stated that Dr. Meyers agreed to and signed a consent agreement to participate in a Board approved program for treatment. Instead, Dr. Meyers admitted himself to a treatment program that was not Board approved, which was a violation of his Board Order. He received a Letter of Reprimand for this. Dr. Meyers' case was brought before the Diversion Committee, who recommended that he be assessed by a Board approved program, prior to his return to the practice of medicine. The Diversion Committee also recommended that MAP monitor Dr. Meyers for 90 days prior to returning to practice. The Betty Ford Treatment Center (Betty Ford) did the assessment on Dr. Meyers and they felt he was fit for duty, but agreed that a period of monitoring would be reasonable.

Ms. Cassetta explained that the Board does not have a proposed consent agreement before them because the Board had not yet made a determination regarding Rational Recovery.

MOTION: Patrick N. Connell, M.D., moved to not permit Dr. Meyers to practice until he has completed 90 days of monitoring by MAP or an equivalent monitoring program; attend three face to face meetings per week, one which may be a Smart Recovery meeting; allow Dr. Meyers to return to practice once he has completed 90 days

NON-TIME SPECIFIC ITEMS (Continued) - MARTIN L. MEYERS, M.D.

successfully and if the Board and Compliance Staff finds his completion of 90 days to be without any signs of relapse or difficulty.
SECONDED: Douglas D. Lee, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

Ms. Cassetta reminded the Board members that there is still the underlying case against Dr. Meyers. In order for him to return to practice Dr. Meyers would need to be placed on MAP Probation. She will include this as part of the interim consent agreement. This case will be brought back as a formal interview.

On Thursday, June 10, 2004, Ms. Cassetta presented the interim consent agreement for their review and approval. Patrick N. Connell, M.D., recommended changing the consent agreement to state the respondent may substitute a Smart Recovery meeting for an AA meeting a maximum of one time per week.

MOTION: Patrick N. Connell, M.D., moved to adopt the interim consent agreement as amended.
SECONDED: Ingrid E. Haas, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

FORMAL INTERVIEWS (Continued)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
2.	MD-02-0713A	F.H.	HARA P. MISRA, M.D.	14933	Case tabled until the August 2004 Board Meeting.

Ram R. Krishna, M.D., recused himself from this matter. Hara P. Misra, M.D., appeared before the Board with his attorney Peter F. Fisher.

Mr. Fisher explained that Dr. Misra's counsel, attorney Stephen Myers, withdrew last Friday. He requested that the formal interview be postponed; because he just received the Dr. Misra's file this morning. Edward J. Schwager, M.D., granted Mr. Fisher's request. He stated that this case and case# MD-02-0749A will be added to the August 2004 Board meeting.

MOTION: Edward J. Schwager, M.D., moved to table this matter until the August 2004 Board meeting.
SECONDED: William R. Martin III, M.D.
VOTE: 9-yay, 0-nay, 1-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
3.	MD-02-0749A	AMB	HARA P. MISRA, M.D.	14933	Case tabled until the August 2004 Board Meeting.

MOTION: Edward J. Schwager, M.D., moved to table this matter until the August 2004 Board meeting.
SECONDED: William R. Martin III, M.D.
VOTE: 9-yay, 0-nay, 1-abstain/recuse, 2-absent
MOTION PASSED.

NON-TIME SPECIFIC ITEMS (Continued)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
15.	MD-04-L091A	L.I.	BARUCH D. ROSEN, M.D.	N/A	Deny licensure.

Baruch D. Rosen, M.D., made a statement at the call to the public. He submitted his written statement to the Board. A previous director of the Arizona Medical Board encouraged him to apply for licensure. He took a Special Purpose Examination (SPEX). After his revocation, he has had time to deal with the consequences of his behavior. He believed he would return to the practice of medicine. He apologized to the Board for his prior actions. He requested that the Board reconsider his application for reactivation of his license.

J.K. made a statement at the call to the public. He is a Board Certified General Surgeon. He worked with Dr. Rosen several years ago. J.K. stated that he has never observed any mismanagement in the care of his patients.

Lisa Bruning, Senior Licensing Investigator, reviewed this case with the Board. Dr. Rosen's license was previously revoked with the state because many surgeries fell below the standard of care. He also claimed he was Board Certified, but was not. He surrendered his DEA registration in 1986 yet administered a Schedule II controlled substance.

NON-TIME SPECIFIC ITEMS (Continued) - BARUCH D. ROSEN, M.D.
Edward J. Schwager, M.D., stated that a current evaluation has not been submitted to the Board that Dr. Rosen would be competent to return to the practice of medicine. Dr. Martin asked if Dr. Rosen would be current on his continuing medical education (CME) if the Board were to re-activate his license. Dr. Connell stated that Dr. Rosen's issues are moral, ethical, and honesty issues, which CME would not necessarily remediate. He stated that there has been no evidence to show that Dr. Rosen has demonstrated rehabilitation of those issues as required by statute. He suggested that Dr. Rosen's application be denied.

MOTION: Patrick N. Connell, M.D., moved to deny the application for licensure based on failure to meet A.R.S.§ 32-1458(A)(4), A.R.S. § 32-1422(A)(4), and (C).
SECONDED: William R. Martin III, M.D.

William R. Martin III, M.D., stated that there is a question of competency. Although, Dr. Rosen has made attempts to remediate his competency issues. He would support denial, because of the moral and ethical lapses that were demonstrated in the past. Edward J. Schwager, M.D., agreed. He noted there is no information on Dr. Rosen's current status. He did take the special purpose examination (SPEX) in 2001, which indicated that Dr. Rosen was not yet ready for practice and needed additional treatment.

ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board member was absent when this matter was considered: Sharon B. Megdal, Ph.D. The following Board members were absent from the meeting: Tim B. Hunter, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-03-0508A MD-03-0508B MD-03-0508C	G.T.	AUGUSTA S. ROTH, M.D. ERIC BENJAMIN, M.D. TODD D. LEVINE, M.D.	17184 15965 26977	Uphold the Executive Director's Dismissal.

G.T. made a statement at the call to the public. He stated that his son shown tremendous progress and instructed Dr. Benjamin not to re-prescribe the drugs. Not only did they re-prescribe, they doubled it. His son became unresponsive.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
2.	MD-03-0479A	H.M.	JOHN J. COREY, M.D.	18509	Uphold the Executive Director's Dismissal.
3.	MD-03-1104A	M.M.	CHARLES A. EVERLY, M.D.	28130	Uphold the Executive Director's Dismissal.
4.	MD-03-1274A	S.S.	SCOTT C. FORRER, M.D.	19296	Uphold the Executive Director's Dismissal.
5.	MD-03-0048A	J.C.	MITCHELL C. KAYE, M.D.	25021	Uphold the Executive Director's Dismissal.

J.C. made a statement at the call to the public. He submitted a copy of his statement to the Board. Although there were seven items in the complaint, the investigation ignored points 3,4,5, and 7. He informed Dr. Kaye of bleeding problems after surgery. He began to hemorrhage in the recovery room. J.C. stated that his wife suggested to Dr. Kaye, that J.C. see a hematologist. Dr. Kaye ignored that advice. He does not want this to happen again to anyone else.

Beatriz Garcia Stamps, M.D., M.B.A., Board Medical Director, reviewed this case with the Board. She stated that there are eight allegations. An Outside Medical Consultant (OMC), a Board Certified Urologist, reviewed this case. He found that Dr. Kaye attended or supervised care of the patient throughout the course of the relationship. There is no evidence that negligence or lack of surgical skill contributed to the problems encountered by the patient. The OMC found no deviations from the standard of care.

Case number 5 was pulled from the block vote for individual consideration. William R. Martin, III, M.D., asked Dr. Stamps what the typical blood loss for this type of surgery is. Dr. Stamps stated that according to the OMC there was 2000 cubic centimeters (cc's). She stated that the records indicate orders totaling 4 units throughout the entire admission. Dr. Martin stated that J.C. stated at the call to the public that it was 8 units. Dr. Stamps clarified that those 8 units relate to other admissions, but in the specific first admission, there were 4 units ordered. Dr. Martin questioned the physician's medical records regarding a history of bleeding problems. Dr. Stamps pointed out that the admission record for the patient from the hospital records indicates the patient had no history of bleeding.

MOTION: Ram R. Krishna, M.D., moved to uphold the Executive Director's dismissal.
SECONDED: Patrick N. Connell, M.D.

NON-TIME SPECIFIC ITEMS (Continued) - MITCHELL C. KAYE, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
6.	MD-03-0795A MD-03-0795B MD-03-0795C	A.W.	SAUL AMBER, M.D. JOHN W. CURTIN, M.D. NORBERTO ADAME, M.D.	10916 3809 28315	Re-review this case to determine if there is evidence to warrant brining one or more of the physicians involved for a formal interview.

Patrick N. Connell, M.D., recused himself from this matter.

John W. Curtin, M.D., made a statement at the call to the public. He stated that he does not work for the County Hospital. The patient had Maricopa Managed Care. The patient took his own life. He had adequate pain medication prescribed through pain management, although, it appeared that the patient was taking more than prescribed. Later the patient was found to have pancreatic cancer that spread to the lung. The patient was found to be intoxicated and had three types of narcotics that were not prescribed by the physicians at the time of death.

A.W. made a statement at the call to the public. He stated that the autopsy proved that the patient had cancer. The patient had weight loss, no appetite, and had agonizing pain. The patient's pain would last for 1-2 hours. Physicians must improve communication between each other when a patient has to go between multiple facilities.

Saul Amber, M.D., made a statement at the call to the public. He stated that pancreatic cancer is one of the hardest cancers to detect. He is not on staff at the County Hospital. He saw the patient on several occasions and suggested that he have a Magnetic Resonance Imaging (M.R.I.) performed, but he did not have insurance. The patient was an Arizona Healthcare Cost Containment System (AHCCCS) patient. Dr. Amber stated there was nothing he could have done. He could not even have lab tests performed because the patient could not pay for them.

Case number 6 was pulled from the block vote for individual consideration. William R. Martin, III, M.D., expressed several concerns about this case. Dr. Martin stated that there was a bad outcome, yet from the Investigational Report, there is no one held responsible for the patient's problems. The patient's complaints and symptoms were never addressed. The report stated as a mitigating factor that the patient was poor and on AHCCCS. Dr. Martin recommended that this case be returned to Board staff for further investigation. Ram R. Krishna, M.D., agreed and stated that the physicians said that pancreatic cancer is hard to diagnose with an ultrasound, yet there were other symptoms involved with the patient. Edward J. Schwager, M.D., stated that the patient had multiple physicians at different facilities, which resulted in fragmented care and poor communication. There were also financial concerns. However, Dr. Schwager stated that a further investigation would be appropriate to determine if a violation of the Medical Practice Act or unprofessional conduct occurred somewhere in the patient's care.

MOTION: Sharon B. Megdal, Ph.D., moved to re-review this case to determine if there is evidence to warrant bringing one or more of the physicians involved, for a formal interview.
SECONDED: William R. Martin, III, M.D.
VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
7.	MD-03-1076A	J.V.	MANINDER S. KAHLON, M.D.	23074	Uphold the Executive Director's Dismissal.
8.	MD-03-1199A MD-03-1199C	M.D.	MARK E. DONNELLY, M.D. CARRIE J. MONROY, M.D.	18917 28534	Uphold the Executive Director's Dismissal.

Case number 8 was pulled from the block vote for individual consideration. Douglas D. Lee, M.D., recused himself from this matter. William R. Martin, M.D., commented that there are patients that are illiterate and it is the physician's responsibility to formalize their complaints so they don't feel intimidated. He would like to agendize this subject at an off-site meeting.

MOTION: Sharon B. Megdal, Ph.D., moved to uphold the Executive Director's dismissal.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
9.	MD-03-0936A	E.S.	PAUL E. ENGLISH, M.D.	19375	Uphold the Executive Director's Dismissal.

B.H. appeared before the Board on behalf of E.S. at the call to the public. She stated that Dr. English has committed unprofessional conduct. B.H. referred to Dr. English's patient records and stated they are less than adequate. The lump was

NON-TIME SPECIFIC ITEMS (Continued) - PAUL E. ENGLISH, M.D.

there for two months. He did not accurately document her records by recording that there was a blister on E.S.'s face. E.S. asked Dr. English to do a biopsy, but he discouraged her from that. E.S. keeps excellent records. Cancer was later detected and was told by Dr. English that he got all of the cancer after her first surgery. The extent of the cancer was not discovered until a specialist performed another surgery. B.H. stated that Dr. English's records were not complete.

Case number 9 was pulled from the block vote for individual consideration. Sharon B. Megdal, Ph.D., asked for clarification from Board staff regarding the recording of phone conversations. Board staff clarified that there are calls recorded, but the caller is informed of this when it occurs.

MOTION: Sharon B. Megdal, Ph.D., moved to uphold the Executive Director's dismissal.
SECONDED: William R. Martin, III, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
10.	MD-03-0379A MD-03-0379B	M.M.	ANTONIO PENA, M.D. TARIQ S. AL-MUTAWA, M.D.	22541 30032	Uphold the Executive Director's Dismissal.
11.	MD-03-1000A	G.K.	SYLVAIN SIDI, M.D.	8458	Uphold the Executive Director's Dismissal.

Robert P. Goldfarb, M.D., and Edward J. Schwager, M.D., recused themselves from this matter.

MOTION: Ram R. Krishna, M.D., moved to uphold the Executive Director's dismissal of case numbers 1 through 11, except case numbers 5, 6, 8 and 9, which were discussed individually.
SECONDED: William R. Martin III, M.D.
VOTE: 9-yay, 0-nay, 2-abstain/recuse, 1 absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
16.	MD-03-0818A	AMB	ROBERT P. RIVERA, M.D.	18575	Dismissed.
17.	MD-03-0552A	M.C.	S. GARY SERBIN, M.D.	17526	Dismissed.

M.C. made a statement at the call to the public. She stated that a splint should have been put into her finger.

Case number 17 was pulled from the block vote for individual consideration. Robert P. Goldfarb, M.D, confirmed with Board staff that there were conflicting opinions regarding this case, which is why it is before the Board for dismissal.

MOTION: Ram R. Krishna, M.D., moved to dismiss this case.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
18.	MD-03-0916B MD-03-0916C	D.G.	RUSSELL G. COHEN, M.D. JAY A. KATZ, M.D.	25011 9855	Dismissed.

Case number 18 was pulled from the block vote for individual consideration. Robert P. Goldfarb, M.D., stated that he knows Russell G. Cohen, M.D., but that will not affect his ability to adjudicate this case. Sharon B. Megdal, Ph.D., confirmed with Board staff that there were conflicting opinions regarding this case, which is why it is before the Board for dismissal. Dr. Megdal suggested that an Executive Director (E.D.) Memo be included with these types of cases with an explanation.

MOTION: Sharon B. Megdal, Ph.D., moved to dismiss this case.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
19.	MD-03-0917A	A.O.	SEAN J. MCCAFFERTY, M.D.	25384	Dismissed.

Case number 19 was pulled from the block vote for individual consideration. Sharon B. Megdal, Ph.D., pulled this case for the same reason on number 18. Her question was addressed.

NON-TIME SPECIFIC ITEMS (Continued) - SEAN J. MCCAFFERTY, M.D.
MOTION: Sharon B. Megdal, Ph.D., moved to dismiss this case.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
20.	MD-03-0673A	S.O.	ELLEN J. GUSTAFSON, M.D.	18895	Dismissed.

Case number 20 was pulled from the block vote for individual consideration. Becky Jordan recused herself from this case. Edward J. Schwager, M.D., stated that he could not tell if the recommendation for this case was for a dismissal or not. Philip Scheerer, M.D., Board Medical Consultant, reviewed this case with the Board. There was a disagreement with the medical consultants. Dr. Scheerer could not find that the physician did anything wrong. Barry A. Cassidy, Ph.D., P.A.-C, stated that this case was referred to him for dismissal, but thought it would be more appropriate for the Board to dismiss.

MOTION: Edward J. Schwager, M.D., moved to dismiss this case.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
21.	MD-03-0649A	AMB	LUIS ALFONSO MUNOZ, M.D.	9794	Dismissed.

Case number 21 was pulled from the block vote for individual consideration. Sharon B. Megdal, Ph.D., questioned Board staff why this case is before the Board for dismissal and asked why the Executive Director (E.D.) could not dismiss it. Barry A. Cassidy, Ph.D., P.A.-C, Executive Director, stated that he was not comfortable dismissing this case.

MOTION: Sharon B. Megdal, Ph.D., moved to go into executive session at 5:09 a.m.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board returned from executive session at 5:15 p.m.

MOTION: Ram R. Krishna, M.D., moved to dismiss this case.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
22.	MD-03-0494A	AMB	MICHAEL W. PEARSON, M.D.	13986	Re-agendize this case as an Advisory Letter for failure to properly supervise a resident resulting in retained gauze following a vaginal delivery.

Case number 22 was pulled from the block vote for individual consideration. Robert P. Goldfarb, M.D., commented that this case might warrant a formal interview or issue an Advisory Letter for failure to properly supervise a resident resulting in retained gauze following a vaginal delivery. The Board members concurred this should be an Advisory Letter. The patient's first twin was delivered vaginally. There was a time frame of approximately three hours between the first delivery and the Cesarean Section (C-Section) of the second twin. The sponge was most likely left prior to the episiotomy repair prior to the C-Section.

MOTION: Edward J. Schwager, M.D., moved to re-agdendize this case as an Advisory Letter for failure to properly supervise a resident resulting in retained gauze following a vaginal delivery.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 10-yay, 1-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
23.	MD-03-1209A	J.V.	ANDREA L. DARBY-STEWART, M.D.	27187	Dismissed.
24.	MD-03-0965A	A.T.	KENNETH M. JONES, M.D.	29766	Dismissed.

NON-TIME SPECIFIC ITEMS (Continued)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
25.	MD-03-0874A	K.S.	RICHARD T. GOTTLIEB, M.D.	16089	Dismissed.
26.	MD-03-0656B	AMB	L. ALFONSO MUNOZ, M.D.	9794	Dismissed.

Case number 24 was pulled from the block vote for individual consideration. Robert P. Goldfarb, M.D., stated that the bank repossessed this physician's computers. The computers contained patients' confidential records. He does not see how the physician would be at fault, since this was out of his control. He requested that the Executive Director look into this matter regarding HIPAA and report back to the Board at the August 2004 Board meeting.

MOTION: Ram R. Krishna, M.D., moved to dismiss this case.
SECONDED: William R. Martin, III, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Ram R. Krishna, M.D., moved to dismiss case numbers 16 through 26, except case numbers 17 through 22, and 26, which were considered individually.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Executive Director's Report

Agency Reports:

Fiscal Year 2004 Agency Reports

Ram R. Krishna, M.D., asked for an update on the agency's backlog. Barry A. Cassidy, Ph.D., P.A.-C, Executive Director, informed them that the Arizona Medical Board is above the national standards. He also informed them that there has been an increase of complaints coming into the Board. However, the agency is within its target range for cases that are open over one year. The Board members discussed that the agency's numbers have been increasing every month and asked if resources need to be diverted to another area to improve. Sandra Waitt, Deputy Chief Information Officer, explained that the reports might reflect higher numbers because the tracking mechanism has changed significantly. Dr. Cassidy stated if the time frames to resolve a case were raised over the next year, there would be concern. Barbara Kane, Assistant Director, stated that the agency is looking at the flow of cases through the system. She stated that the cases reflected are not old, but are in the process of being adjudicated. Ms. Kane further stated that the backlog should not be based upon the total number of open cases but should be defined as the number of cases exceeding the Agency's target goals: those cases over 180 days and those cases over 360 days. Currently the number of cases over 180 days is staying at 170-180 and the number of cases over 360 days is staying at 50-55. Sharon B. Megdal, Ph.D., commented that perhaps too many figures are being reported to the Board and if the numbers are not actually referring to a backlog then the numbers should be reported accordingly.

Monitored Aftercare Program Rules

Christine Cassetta, Board Counsel, clarified her memo with the Board regarding the strike three analyses. The Board members discussed what they consider a relapse. Ms. Cassetta clarified that each case would be determined on its own merits. The Board members requested that Ms. Cassetta make a chart for a better understanding of the process regarding relapses under the Monitored Aftercare Program (MAP).

MOTION: Patrick N. Connell, M.D., moved to revise the Monitored Aftercare Program (MAP) rules to delete R4-16-604 (D) and edit (C) to say number six, comply with any additional requirement that the Board deems necessary to determine the physician's ability to safely resume the practice of medicine; return to the Board for consideration at the August 2004 Board meeting.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Civil Penalties

The Board members considered Christine Cassetta's, Board Counsel, memo to impose civil penalties as part of the Board's discipline. Sharon B. Megdal, Ph.D., referred to Ms. Cassetta's memo and clarified this is to amend the Board's disciplinary rules. She also stated this list should not be exclusive in order that penalties could be considered for cases involving other statutory violations or severe misconduct.

MOTION: Robert P. Goldfarb, M.D., moved that the recommendation of Civil Penalties to be added to the disciplinary rules.

NON-TIME SPECIFIC ITEMS (Continued) – Civil Penalties

SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Barry A. Cassidy, Ph.D., P.A.-C, Executive Director, asked the Board members for clarification regarding a guideline of dollar amounts for cases. Christine Cassetta, Board Counsel, reiterated that the majority of the civil penalties would involve ill-gotten gains and can be assessed appropriately.

PROPOSED CONSENT AGREEMENT

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-02-0804A	AMB	BURT FAIBISOFF, M.D.	13213	Letter of Reprimand for performing an inappropriate surgical procedure and for excising excessive tissue, resulting in excessive scarring and flattening of the buttocks.

MOTION: Sharon B. Megdal, Ph.D., moved to accept the proposed consent agreement as written.
SECONDED: Robert P. Goldfarb, M.D.
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

FORMAL INTERVIEWS (Continued)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
5.	MD-03-0957A	AMB	OSAMA M.A. ABDELATIF, M.D.	20062	Advisory Letter for a misdiagnosis of a malignant melanoma. A.R.S. § 32-1401(3)(b) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Edward J. Schwager, M.D., recused himself from this matter. Osama M.A. Abdelatif, M.D., appeared before the Board with his attorney Dan Cavett.

Philip Scheerer, M.D., Board Medical Consultant, reviewed this case with the Board. The allegation is that Dr. Abdelatif failed to diagnose a malignant melanoma.

Dr. Abdelatif made a statement to the Board. Dr. Abdelatif stated that he did fail to diagnose this patient. He does not have an explanation for it because it was not a difficult diagnosis. He has apologized to his patient and expressed his remorse and regret. Dr. Abdelatif stated that the patient wrote back to him and forgave him.

Douglas D. Lee, M.D., presenting Board member, began the questioning of Dr. Abdelatif. Dr. Abdelatif reviewed his routine when he examines a specimen. Dr. Lee reiterated that the first thing he rules out on a lesion is malignancy. Dr. Abdelatif stated that this lesion was within a Nevus, which are normally removed and the majority of them do not return. Dr. Lee asked Dr. Abdelatif if pathologists receive and review requisitions. Dr. Abdelatif stated that they do and it is very important in making a correct diagnosis. Dr. Abdelatif agreed with Dr. Lee that when he went back to review the slide, it was obvious that there was a malignancy. The Board members began questioning Dr. Abdelatif.

Mr. Cavett made a statement to the Board on behalf of Dr. Abdelatif. He stated that Dr. Abdelatif has admitted to this misdiagnosis. The patient was a very young girl that had a lesion metastasize to a distant area in her thigh. Two other pathologists said this had already metastasized. This was a congenital mole that had changed. A previous physician burned it off and the mole came back two-years later. Dr. Abdelatif is well trained. He is very devastated by this. Mr. Cavett asked that this matter be dismissed.

Dr. Lee stated that in 1997 the lesion was there. Others, also, dropped the ball regarding this patient's diagnosis. The lesion was biopsied in 1999 and the pathology consultants reported that it was probable that the lesion was malignant when Dr. Abdelatif was involved. However, it has not been determined if that delay of approximately 16 months resulted in harm to the patient. Dr. Lee recommended a finding of unprofessional conduct for a misdiagnosis of a malignant melanoma.

FORMAL INTERVIEWS (Continued) - OSAMA M.A. ABDELATIF, M.D.

MOTION: Douglas D. Lee, M.D., moved for a finding of unprofessional conduct for a misdiagnosis of a malignant melanoma in violation of A.R.S. § 32-1401(26)(q) – Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: William R. Martin, III, M.D.
VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Douglas D. Lee, M.D., moved to issue an advisory letter for a misdiagnosis of a malignant melanoma. A.R.S. § 32-1401(3)(b) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Becky Jordan
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Chris Wertheim. The following Board member was recused from the motion: Edward J. Schwager, M.D. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

NON-TIME SPECIFIC ITEMS (Continued)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
13.	MD-04-L032A	L.I.	IVYL W. WELLS, M.D.	N/A	Uphold the Executive Director's Denial of License.

Ivyl W. Wells, M.D., made a statement at the call to the public with his attorney James Taylor. He asked that the Board consider the materials before them.

Mr. Taylor made a statement to the Board at the call to the public on behalf of Dr. Wells. The restrictions from the Idaho Board are similar to the restrictions that every family practitioner experience. He requested that the Board reconsider because there are mitigating circumstances. He suggested that the Board issue a probationary license, suspend his application for licensure at this time, or allow Dr. Wells to withdraw his application.

Lisa Bruning, Senior Licensing Investigator, reviewed this case with the Board. Dr. Wells does not meet the requirements for licensure in Arizona. He has a restricted license in the State of Idaho for failing to meet the standard of care. He had three malpractice cases with two resulting in payment. Dr. Wells was advised of Arizona's basic license requirements.

Patrick N. Connell, M.D. stated that Dr. Wells does not meet the statutory requirements of A.R.S. § 32-1422(A)(6), (D), (A)(4), and (C).

MOTION: Patrick N. Connell, M.D., moved to uphold the Executive Director's denial of license based on failure to meet A.R.S. § 32-1422(A)(6), (D), (A)(4), and (C).
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board members were absent from the meeting: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
14.	MD-04-L100A	L.I.	RICHARD M. WODKA, M.D.	N/A	License Reactivation Denied.

Edward J. Schwager, M.D., recused himself from this matter.

Lisa Bruning, Senior Licensing Investigator, reviewed this case with the Board. Michelle Semenjuk, Licensing Division Chief, clarified for the Board members that Richard M. Wodka signed a consent agreement for his license to be inactive with cause.

MOTION: Douglas D. Lee, M.D., moved to deny Dr. Wodka's request for license reactivation based on failure to meet A.R.S. § 32-1422(3), (A)(4), (C), and committing unprofessional conduct A.R.S. § 32-1401(26)(a), (f), (q), (z) and (jj).
SECONDED: Ingrid E. Haas, M.D.

NON-TIME SPECIFIC ITEMS (Continued) - RICHARD M. WODKA, M.D.

ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Chris Wertheim. The following Board members recused themselves from the motion: Edward J. Schwager, M.D. The following Board members were absent from the meeting: Tim B. Hunter, M.D.
VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

SPECIAL PRESENTATION

Federation of State Medical Boards Special Presentation

Lisa Robins, Vice President, and Stacy Langford, on the Board of Directors, both from the Federation of State Medical Boards (FSMB) made a presentation to the Board. They explained that the FSMB's goal is the continual improvement in the quality, safety, and integrity of healthcare, through the development and promotion of high standards for licensure and practice. Ms. Robins explained that they exist for all of the state Medical Boards to provide services and support. They explained the FSMB's past history, current course of action, future goals, and International Organizational plans.

NON-TIME SPECIFIC ITEMS (Continued)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
28.	MD-00-0370	J.S.	BRUCE HUNTER, M.D.	24075	Termination of Board Order Denied; Dr. Hunter's Probation will go full term and he may not request early termination.

Patrick N. Connell, M.D., stated that there were multiple and serious allegations regarding this case. Probation was given for good reason. Christine Cassetta, Board Counsel, explained that the original Order gave Bruce Hunter, M.D., the option of applying for early termination of his Board order. Sharon B. Megdal, Ph.D., stated that she has a problem granting this request because of a physician's reason for his request regarding a job opportunity.

MOTION: Patrick N. Connell, M.D., moved to deny the request for termination of Board Order; Dr. Hunter's probation will go full term and he may not return to the Board to request early termination.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 10-yay, 1-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
29.	MD-00-0139A MD-02-0452A	AMB	DANIEL DE LA PAVA, M.D.	11945	Motion for Rehearing or Review Denied.

Attorney Gordon Lewis made a statement at the call to the public on behalf of Daniel De La Pava, M.D. He asked that the Board consider this case carefully. Dr. De La Pava has not performed the procedures in question for four years. The findings of the three cases do no support the discipline imposed. Mr. Lewis stated that Dr. De La Pava has requested that the Board reconsider this matter.

Ram R. Krishna, M.D., recalled the complexity of this case and recommended that the motion for rehearing or review be denied. Edward J. Schwager, M.D., stated that Mr. Lewis' indicated prejudice as evidenced at the formal interview by the presentation of Dr. De La Pava of a consent agreement prior to the formal interview. Christine Cassetta, Board Counsel, clarified that Mr. Lewis' argument was that Dr. De La Pava was offered a consent agreement prior to the meeting and when the Board asked him if he would accept it and he declined, the Board members were prejudiced against his client. Ms. Cassetta informed the Board that she reviewed the formal interview transcript and the exchange between Dr. De La Pava and the Board came about after he indicated that he did not perform this type of surgery any longer. The Board then asked if his no longer performing these procedures was clarified in a consent agreement with the Board. The Board was informed that it was not. Dr. De La Pava was then offered the opportunity to enter into a consent agreement to codify that he would not do these procedures. He declined and the interview proceeded. Sharon B. Megdal, M.D., recommended that the subject of offering consent agreements should be agendized for a later meeting for discussion.

MOTION: Ram R. Krishna, M.D., moved to deny the motion for rehearing or review.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NON-TIME SPECIFIC ITEMS (Continued)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
30.	MD-01-0772	J.V.	RICHARD G. BOTTIGLIONE, M.D.	14927	Decree of Censure for unprofessional conduct; Obtain Board staff pre-approved CME within one year of the effective date of the Order for thirty hours of "Wound Closure Techniques" and six hours of "Pathology", providing to the Executive Director satisfactory proof of attendance for both.

J.V. made a statement at the call to the public. She stated that she has excessive scarring as a result of surgery from Dr. Bottiglione. She stated that Dr. Bottiglione dealt with scarring differently in order that the scarring would not look like scarring from surgery but from an accident.

Robert P. Goldfarb, M.D., stated that this is a very egregious case of excising lesions and not sending them to pathology. He stated that a Decree of Censure would not be sufficient. Ann Marie Anderson, Assistant Attorney General, reviewed this case with the Board. Ms. Anderson stated that Dr. Bottiglione was cooperative with the Attorney General's Office and he did complete 39 hours of continuing medical education (CME) for mole surgery on his own. Dr. Goldfarb stated that this physician has been in practice for 25 years and for him to not send a specimen to pathology is outrageous. Dr. Goldfarb suggested a stayed revocation. He questioned if this could have happened to other specimens. Edward J. Schwager, M.D., stated that the materials the Board has would not support a stayed revocation. William R. Martin, III, M.D., suggested looking at the physician's past history with the Board. Sharon B. Megdal, Ph.D., stated that this was referred to formal hearing. She would support the Decree of Censure in this case. The CME will help the physician avoid the problem in the future.

MOTION: Sharon B. Megdal, Ph.D., moved to rescind the referral to formal hearing and accept the consent agreement as written.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board members voted against the motion: Robert P. Goldfarb, M.D. and Douglas D. Lee, M.D. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 9-yay, 2-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
31.	MD-01-0436	AMB	MITCHEL A. LIPTON, M.D.	11223	Letter of Reprimand for unprofessional conduct.

Mitchel A. Lipton, M.D., made a statement at the call to the public. He stated that he has been a hand surgeon in the Valley for 25 years. He stands by what he signed and takes responsibility for what happened in surgery seven years ago. He reviewed the details of the operation from his point of view. He has changed his approach to surgery to wait until all things that are needed are in the room, such as x-rays etc. He requested that the Board impose an Advisory Letter instead of a Letter of Reprimand.

Edward J. Schwager, M.D., reiterated that this physician declined a formal interview. A consent agreement was executed. Ram R. Krishna, M.D., stated that there was patient harm involved.

MOTION: Ram R. Krishna, M.D., moved to rescind referral to formal hearing and accept the consent agreement as written.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
32.	MD-99-0731	D.C.	KENNETH WESTFIELD, M.D.	13740	Letter of Reprimand for unprofessional conduct.

MOTION: Patrick N. Connell, M.D., moved to rescind the referral to formal hearing and accept the consent agreement as written.
SECONDED: Ram R. Krishna, M.D.

NON-TIME SPECIFIC ITEMS (Continued) - KENNETH WESTFIELD, M.D.

ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
33.	MD-03-0050A	I.P.	PADMAVATHI VEERAPANENI, M.D.	28740	Letter of Reprimand for ordering and administration of Heparin that contributed to or caused a patient's death.

Christine Cassetta, Board Counsel, confirmed that the Board does not need to do a roll call vote for draft Findings of Fact, conclusions of law, and Order.

MOTION: Ram R. Krishna, M.D., moved to accept the draft Findings of Fact, conclusions of law, and Order as written.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The meeting adjourned at 6:02 p.m.

THURSDAY, JUNE 10, 2004

CALL TO ORDER

Edward J. Schwager, M.D., Chair, called the meeting to order at 8:02 a.m.

ROLL CALL

The following Board members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board member arrived at 8:06 a.m.: Ingrid E. Haas, M.D. The following Board member was absent from the meeting: Tim B. Hunter, M.D.

CALL TO THE PUBLIC

Statements issued during the call to the public appear beneath the case referenced.

FORMAL HEARING MATTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-04-0163A	AMB	JACK I. DODGE, M.D.	15597	Dr. Dodge's license be suspended on the effective date of the entered Order in this matter until the Board receives written proof that Dr. Dodge has successfully completed a Board approved inpatient evaluation as recommended by Dr. Sucher, he complies with the recommendations of the evaluation/treatment center, and the Board approves his return to the practice of allopathic medicine; Upon Respondent's return to practice an Order shall be issued placing Respondent on probation for five years pursuant to the terms of the Board's Monitored Aftercare Program. Said Probation shall also require Respondent to obey all federal, stated and local laws, all rules governing the practice of medicine in Arizona, and remain in compliance with any court ordered criminal probation, payments and other orders.

The mother of Jack I. Dodge, M.D., made a statement to the Board at the call to the public. She stated that her son voluntarily went into rehab when he was located in the Midwest. He has been drug-free for almost two and a half years and has turned his life around. Dr. Dodge has received no help from the Board except for the suggestion that he return to rehab. She stated that her son refused to return to rehab because he has already completed rehab and has been drug free.

Dean Brekke, Assistant Attorney General, made a statement to the Board. Mr. Brekke stated it was determined that Dr. Dodge was not compliant with his Monitored Aftercare Program in South Dakota. Because of that, Dr. Dodge was interviewed and it was found that Dr. Dodge had not been monitored for a period of time, which leads to the request that he participate in an

FORMAL HEARING MATTERS (Continued) - JACK I. DODGE, M.D.
inpatient evaluation program to determine if he required additional treatment. Mr. Brekke also stated that Dr. Dodge admitted to a relapse within the past year, which is why there is a need for an additional evaluation.

Dr. Dodge made a statement to the Board. Dr. Dodge stated that he was willing to do random drug tests and attend Alcoholics Anonymous (AA) meetings. He stated that he has not worked in the state of Arizona for five years, yet the Board has said he is a danger to society.

Sharon B. Megdal, Ph.D., recommended the following grammatical corrections to the Findings of Fact:

- Paragraph 4, 8, and 10: Correct the spelling of "Hazeldon" and "Hazelton" to "Hazelden."
- Paragraph 9: Add "his" between "that" and "stay" and change "were" to "was." Also, correct the spelling of "Hazelton" to "Hazelden."
- Paragraph 20: Last line, add "be" between "he" and "placed."
- Paragraph 25: Second line, change "due" to "do."

MOTION: Sharon B. Megdal, Ph.D., moved that the Board Adopt Findings of Fact numbers 1 through 31 as recommended by the Administrative Law Judge with grammatical corrections as stated above.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Sharon B. Megdal, Ph.D., moved that the Board Adopt Conclusions of Law numbers 1, 2, 3, 4, and 6, deleting number 5 and renumbering 1-5.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Dr. Megdal reviewed the recommended revised language to modify the Order as recommended by the Administrative Law Judge.

MOTION: Sharon B. Megdal, Ph.D., based on the Findings of Fact and Conclusions of Law, moved to modify the Order recommended by the Administrative Law judge as follows: Dr. Dodge's license be suspended on the effective date of the entered Order in this matter until the Board receives written proof that Dr. Dodge has successfully completed a Board approved inpatient evaluation as recommended by Dr. Sucher, he complies with the recommendations of the evaluation/treatment center, and the Board approves his return to the practice of allopathic medicine; Upon Respondent's return to practice an Order shall be issued placing Respondent on probation for five years pursuant to the terms of the Board's Monitored Aftercare Program. Said Probation shall also require Respondent to obey all federal, stated and local laws, all rules governing the practice of medicine in Arizona, and remain in compliance with any court ordered criminal probation, payments and other orders.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
2.	MD-02-0216A MD-02-0764A MD-02-0765A MD-03-0504A	AMB	ABEDON A. SAIZ, M.D.	24387	Prior Order and the terms of that Order are to remain in effect. Stayed Revocation and Probation for ten-years to be put in place, in addition to chart reviews to be conducted every six months. Dr. Saiz shall report to the Board within five-days notification of a pending malpractice action, a restriction in hospital privileges or at a freestanding surgery center. Dr. Saiz shall be assessed the costs of the hearing within six-months of the effective date of the entered Order in this matter. Dr. Saiz may petition the Board no sooner than five-years of the effective date of this Order for removal of Probation.

N.S. appeared before the Board on behalf of her husband, Dr. Saiz, at the call to the public on Wednesday, June 9, 2004. She works with her husband overseeing his office. The Arizona Medical Board set the terms of Dr. Saiz's probation and he has

met those terms. She has maintained Dr. Saiz's logs and has been in contact with the Board. All of the cases before the Board happened prior to Dr. Saiz's probation. Dr. Saiz lost his privileges from the hospital in January of 2004 and the Board has interpreted that as incompetence. She asked why we are here again. Why did this change? These are all old cases.

S.W. made a statement at the call to the public on Wednesday, June 9, 2004. She stated that she is a patient of Dr. Saiz. She is a duty chaplain at the hospital. The hospital announced that Dr. Saiz would no longer provide services there. Dr. Saiz is a very passionate and caring physician with patients who love him and care for him. She asked that the Board make their decision carefully. Dr. Saiz is very cautious. The hospital is interested in the money. Dr. Saiz counsels his patients about their surgeries and keeps them informed.

S.D. made a statement at the call to the public on Wednesday, June 9, 2004. She represents Dr. Saiz on a number of matters. She reiterated the powers and duties of the Arizona Medical Board. Dr. Saiz came to Arizona to raise his family. Dr. Saiz performed 4,000 surgeries with seven deaths that occurred.

Glen Nudelman, M.D., made a statement at the call to the public. The Surgery Center and the community do not think that Dr. Saiz is a threat. The physicians in Lake Havasu believe that Dr. Saiz has met the standard of care. These are actions that have caused significant damage to Dr. Saiz's defense.

Nick Awad, M.D., made a statement at the call to the public on behalf of Dr. Saiz. He is a radiologist in Lake Havasu. He would like the Board to reconsider and give Dr. Saiz a chance and give the community their doctor back.

M. Kazmi, M.D., made a statement at the call to the public. Dr. Kazmi stated that Dr. Saiz is the greatest vascular surgeon he has ever met in his life. Dr. Saiz has the support of the community.

Stephen Wolf, Assistant Attorney General, made a statement to the Board. He stated that the Board has a duty to protect the citizens of Arizona. Mr. Wolf pointed out that the Administrative Law Judge concluded that Dr. Saiz's conduct was negligent and incompetent. This was based on a four-day hearing that included evidence and testimony from both sides. Mr. Wolf summarized the cases involved in this matter. Mr. Wolf reminded the Board that Dr. Saiz has been before them before regarding other cases that involved gross and repeated negligence. He stated that the Board has also Summarily Suspended his license, pending an Administrative Hearing. Mr. Wolf urged the Board to support the recommended revocation, because Dr. Saiz's record of unprofessional conduct is egregious and poses a risk to the public. Mr. Wolf asked if the Board allows Dr. Saiz to continue practicing medicine, how could they justify that to the family of his next victim.

Attorney Daniel P. Jantsch made a statement to the Board on behalf of Dr. Saiz. He stated that the Administrative Law Judge's recommended order looks like it is one sided. He stated the importance of providing Dr. Saiz a fair hearing. Mr. Jantsch asked the Board to review the evidence of this case carefully. The Board's duty is to protect the public, but also to protect the community and not deprive them of their medical resources. A professional license is a property interest that is protected under the 5th and 14th amendments of the United States Constitution. Dr. Saiz is on probation for five years and should be kept on probation and allowed to practice. Dr. Saiz has met every requirement of his probation. He asked the Board to keep Dr. Saiz in practice.

MOTION: Ram R. Krishna, M.D., moved to go into executive session at 10:10 a.m.
SECONDED: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board returned from executive session at 10:46 a.m.

Sharon B. Megdal, Ph.D., recommended that Findings of Fact number 90 be clarified to reflect that this present case was prior to the action that was taken against Dr. Saiz for a stayed revocation. She wanted to state for the record because she would like to extend the terms of the stayed revocation for a longer period of probation. Edward J. Schwager, M.D., stated that the Findings of Fact speak for themselves. Christine Cassetta, Board Counsel, clarified for Dr. Megdal that the date of the previous action was included in the Findings of Fact number 93.

MOTION: Sharon B. Megdal, Ph.D., moved that the Board Adopt Findings of Fact numbers 1 through 94 as recommended by the ALJ with the grammatical corrections as submitted by Board Counsel.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

FORMAL HEARING MATTERS (Continued) - ABEDON A. SAIZ, M.D.

Edward J. Schwager, M.D., recommended adding a Findings of Fact that the testimony recorded in the hearing demonstrated that Dr. Saiz is in compliance with the Center for Personalized Education for Physicians (CPEP) recommendations for rehabilitation cited in the testimony of both Drs. Cardone and Kennel. Dr. Schwager cited to the record for this addition.

MOTION: Edward J. Schwager, M.D., moved for an additional Findings of Fact that the testimony recorded in the hearing demonstrated that Dr. Saiz is in compliance with CPEP recommendations for rehabilitation cited in the testimony of both Drs. Cardone and Kennel.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Ram R. Krishna, M.D., moved that the Board Adopt the Conclusions of Law as recommended by the Administrative Law Judge with grammatical corrections as submitted by Board Counsel.
SECONDED: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board members discussed an Order for continuing the existing Stayed Revocation and terms, but extending the Probation to ten-years instead of five-years. Dr. Megdal stated that Dr. Saiz had a heavy workload previously and does not want to see that happen again. The Board members discussed the terms of the Order regarding Probation. Dr. Schwager stated that there has been evidence of rehabilitation from Dr. Saiz. The Board must protect the public, which includes the rehabilitation of physicians and provide services in areas that they may not be available. However, the Board should not allow services in a rural area to be substandard.

MOTION: Edward J. Schwager, M.D., moved that the prior Order and the terms of that Order are to remain in effect. Stayed Revocation and Probation for ten-years to be put in place, in addition to chart reviews to be conducted every six months. Dr. Saiz shall report to the Board, within five-days, notification of a pending malpractice action, a restriction in hospital privileges or at a freestanding surgery center. Dr. Saiz shall be assessed the costs of the hearing within six-months and the effective date of the entered Order in this matter. Dr. Saiz may petition the Board no sooner than five-years of the effective date of this Order for removal of Probation.
SECONDED: Ram R. Krishna, M.D.

Patrick N. Connell, M.D., asked if the maker of the motion would be willing to amend it to include that the physician must practice in a group setting. Dr. Connell explained that Dr. Saiz had had a number of outcomes that reflect poor judgment, poor selection of surgical candidate, poor selection of procedures, and poor documentation. Dr. Connell stated that the rural areas of Arizona deserve the same standard of care as a metropolitan area. Dr. Connell stated that a mentor could be of benefit to Dr. Saiz.

MOTION: Patrick N. Connell, M.D., moved to amend the Probation to require that Dr. Saiz practice in a group setting.
SECONDED: William R. Martin, III, M.D.

The Board members discussed the proposed amendment. Dr. Krishna stated that Dr. Connell's recommendation is good, but recognized that it would not be easy to practice in a group setting in a rural area.

VOTE: 2-yay, 9-nay, 0-abstain/recuse, 1-absent
MOTION FAILED.

ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., and Edward J. Schwager, M.D. The following Board members voted against the motion: Patrick N. Connell, M.D., William R. Martin, III, M.D., and Chris Wertheim. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 8-yay, 3-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-03-0943A	AMB	AMALIA PINERES, M.D.	20943	Draft Findings of Fact, Conclusions of Law, and Order for a Letter of Reprimand for improperly prescribing Fentanyl (Duragesic patch) to a nine-year old child; Probation for one year to include 10 hours of Board staff pre-approved continuing medical education (CME) in pediatric pharmacology and/or pediatric pain management, in addition to the CME required for biennial license renewal; Dr. Pineres may request termination of Probation upon successful completion of the CME.

Edward J. Schwager, M.D., recused himself from this matter. Amalia Pineres, M.D., appeared before the Board with her attorney Steve Myers.

Rudolf Kirschner, M.D., Board Medical Consultant, reviewed this case with the Board. The allegation is that Dr. Pineres improperly prescribed fentanyl (Duragesic patch).

At the beginning of the formal interview Mr. Myers informed the Board that his client was willing to accept a consent agreement offered by Board Staff with the deletion of one finding of fact. Myers identified this finding of fact. Ms. Cassetta noted for the Board that the finding of fact Dr. Pineres disagreed with went to the heart of the matter before them and suggested that the Board disregard the consent agreement and proceed with the formal interview. Dr. Pineres made a statement to the Board. She stated that this case involved the death of a nine-year old boy. The death of the child is extremely excruciating to her. She expressed her sorrow to the family. She has taken this patient's death very hard. The practice of pediatrics has been a blessing and a challenge for her. She made a mistake when she prescribed the fentanyl patch for this child. The patient was taking oral pain medication, but was not working well for him. She has used the patch before. It was one of the few medications available for this child. She reviewed the details of this case with the Board. She stated that she acted outside of the standard of care. She does not believe, though, that the fentanyl was the cause of the child's death. The patient was septic. She also noted that the patient was very dehydrated.

Patrick N. Connell, M.D. presenting Board member, began the questioning of Dr. Pineres. He confirmed with Dr. Pineres that she agrees that prescribing the Duragesic patch was below the standard of care. The concentration was significantly greater than that required for analgesia. She does not dispute that the Fentanyl may have contributed to the child's death. She stated that the child was septic and dehydrated. Dr. Connell reviewed the history of the child's care with Dr. Pineres. The Board members began questioning Dr. Pineres. They clarified issues and details with Dr. Pineres regarding her care of the patient and the lack of obtaining the patient's medical history. Also, Dr. Pineres confirmed that the child was not completely incapable of eating and drinking as previously suggested, but that it was difficult for him.

Mr. Myers made a statement to the Board on behalf of Dr. Pineres. He stated that the levels are below toxic on the lab results, but are significantly above therapeutic. Mr. Myers referred to a report of an expert he had submitted to the Board that noted that there are therapeutic, toxic, and fatal levels found on lab tests and that there is a significant difference between these levels. The Board indicated that it did not have the report Mr. Myers referred to. The family and physician have both suffered.

Dr. Kirschner stated that the issue is not what the child died of, but that a medication was used, which was contraindicated.

Dr. Connell sated that the standard of care violated is that Dr. Pineres prescribed an opiod medication for a nine-year old child that was specifically contraindicated for this age group. Dr. Connell stated that there is a difference in prescribing opiates for children and adults. He agreed with the pathologist that the child died of respiratory depression due to opiate intoxication from the Fentanyl patch. He referred to the mother's detailed events that occurred in the last days of her child's life.

MOTION: Patrick N. Connell, M.D., moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(26)(q) – Any conduct or practice that is or might be harmful or dangerous to the health of the patient or public, and A.R.S. § 32-1401(ll) – Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D., moved for Board staff to Draft Findings of Fact, Conclusions of Law, and Order for a Letter of Reprimand for improperly prescribing fentanyl (Duragesis patch) to a nine-year old child; Probation for one year to include 10 hours of Board staff pre-approved continuing medical education (CME) in pediatric

pharmacology and/or pediatric pain management, in addition to the CME required for biennial license renewal; Dr. Pineres may request termination of Probation upon successful completion of the CME.
SECONDED: Ram R. Krishna, M.D.

The Board members discussed the Letter of Reprimand. Douglas D. Lee, M.D., expressed concerned that the pathologist did not consider the patient's other issues. There were other factors involved with the child's death and the issue is if Fentanyl was the cause of death.

ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board members voted against the motion: Douglas D. Lee, M.D. and Chris Wertheim. The following Board member was recused from this matter: Edward J. Schwager, M.D. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 8-yay, 2-nay, 1-abstain/recuse, 1- absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
2.	MD-03-0703A	AMB	STEVEN SIWIK, M.D.	22916	Advisory Letter for failure to diagnose C1 subluxation. A.R.S. § 32-1401(3)(b) – The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Steven Siwik, M.D., appeared before the Board with his attorney Peter Akmajian. Edward J. Schwager, M.D., stated that he knows Dr. Siwik but that will not affect his ability to adjudicate this case.

Beatriz Garcia Stamps, M.D., M.B.A., Medical Director, reviewed this case with the Board. The allegation is that Dr. Siwik failed to diagnose cervical fracture on x-ray.

Steven Siwik, M.D., made a statement before the Board. He stated that he does not recall the details about this case. He also stated that he has never denied responsibility of this case. The patient was involved in an accident and he interpreted the patient's films as negative. This occurred shortly after he finished his fellowship training as a radiologist and only days after he was in his private practice. He has learned that any time he reviews a cervical spine radiographic series that he always adds dictation regarding the process. He does this without distractions and then moves on to the next case. His first priority is the patient's care.

Ram R. Krishna, M.D., presenting Board member, began the questioning of Dr. Siwik. Dr. Siwik stated that it was an oversight and he missed it. Dr. Krishna confirmed with Dr. Siwik that he now he spends more time with a case. He assumes something is there unless he does not find it. Dr. Krishna stated that the fracture was obvious. The Board members viewed the x-rays. The Board members began questioning Dr. Siwik. The Board members confirmed that the miss rate of a diagnosis is approximately 1 to 3 percent.

Mr. Akmajian stated that Sr. Siwik is a good physician, well trained, and contentious. Since 1999 Dr. Siwik has had 180 hours of continuing medical education (CME). Dr. Siwik has learned from this and has changed his practice. Mr. Akmajian stated that Dr. Siwik has always accepted responsibility for this.

Dr. Krishna stated that this was an error, which Dr. Siwik regrets. The potential harm could have been significant if it had progressed. Dr. Krishna stated that Dr. Siwik recognizes the importance of this. He recommended issuing an Advisory Letter, because it is a minor or technical error that does not warrant discipline.

MOTION: Ram R. Krishna, M.D., moved to issue an Advisory Letter for missing failure to diagnose C1 subluxation. A.R.S. § 32-1401(3)(b) – The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

FORMAL INTERVIEWS (Continued)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
3.	MD-03-0495A	AMB	JASON J. WOO, M.D.	29143	Advisory Letter for the attempted use of forceps and failing to proceed to C-Section causing the death of an infant. The conduct is mitigated by system problems.

Jason J. Woo, M.D., appeared before the Board without legal representation.

Robert Barricks, M.D., Board Medical Consultant, reviewed this case with the Board. The allegation is that Dr. Woo improperly used forceps during a delivery of a high-risk pregnancy.

Ingrid E. Haas, M.D., presenting Board member, began the questioning of Dr. Woo. Dr. Woo reviewed the patient's prenatal history with the Board. He stated that he was at the Phoenix Indian Medical Center, which is severely overrun. Dr. Woo stated that the assignments of physicians for patient care are rotated. He pointed out that there were no high group risk meetings at that time. Dr. Haas reviewed with Dr. Woo the procedures of patient's records since the physicians would rotate care. Dr. Haas questioned Dr. Woo about the labor of a diabetic patient. Dr. Woo stated that it would be preferable to deliver a diabetic patient's baby as soon as possible. He stated that the Phoenix Indian Medical Center does not have the tools or resources that other hospitals have. Dr. Haas asked Dr. Woo if there was fetal distress. Dr. Woo stated that the patient had severe decelerations, so there was urgency about getting the patient delivered quickly. Dr. Haas noted that when Dr. Woo put the forceps on, he had internal monitoring and asked why he would take that monitoring off. Dr. Woo stated that he had an ultrasound. Assisted delivery is not a consistent pull. Dr. Woo stated that there were two applications, which totaled 20 minutes from the time the forceps were inserted to when the baby was delivered. Dr. Woo stated that the reason that a Cesarean section (C-Section) was not performed was an institutional decision. He stated he was locked in at a certain point. Dr. Haas asked Dr. Woo what are the resources were available to him. Dr. Woo stated that he did ask to have the nurses scrub, in the event that a C-Section was needed. Dr. Woo explained that The Phoenix Indian Medical Center had categories for C-Sections, which are urgent, emergent and scheduled C-sections. Dr. Woo said that he would not put himself in those circumstances again. The Board members began questioning Dr. Woo. The Board members clarified that Dr. Woo though he was able to get the baby out faster by using forceps then performing an urgent C-Section.

Dr. Barricks stated that some of the difficulty of the patient was before the delivery, because of the poor monitoring of the mother's blood sugars. Dr. Barricks also stated that the size of the fetus was never measured. Even with the most talented physicians, the use of forceps is difficult.

Ingrid E. Haas, M.D., stated that mid-forceps is a high-risk situation. Some say forceps should be totally eliminated. This was a very poor decision, because of the prenatal care, knowing that the patient was a diabetic, and not knowing the weight of the fetus. The standard of care would be to evaluate the patient for a high-risk delivery and to deliver a fetus safely. The harm in this case was the death of a fetus and injury to the mother. Edward J. Schwager, M.D. stated that he would support unprofessional conduct but not necessarily discipline.

MOTION: Ingrid E. Haas, M.D., moved for a finding of unprofessional conduct in violation A.R.S. § 32-1401(26)(ll) - Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Dr. Haas stated that because of the outcome she recommended a Letter of Reprimand for the inappropriate management of a high-risk pregnancy and delivery. The Board members commented on the lack of the continuity of care at the hospital. They also noted that Dr. Woo was in a difficult situation with the type of staff support and the belief that he could not go to the operating room fast enough. Dr. Haas stated that another option would have been to stop labor. Dr. Schwager recommended issuing an Advisory Letter, because of the mitigating factor of the environment that Dr. Woo was in.

MOTION: Ingrid E. Haas, M.D., moved for Board staff to Draft Findings of Fact, Conclusions of Law, and Order for a Letter of Reprimand for failure to manage a high-risk pregnancy and delivery, resulting in the death of the infant and injury to the mother.
SECONDED: Sharon B. Megdal, Ph.D.
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Ingrid E. Haas, M.D. and Sharon B. Megdal, Ph.D. The following Board members voted against the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 2-yay, 9-nay, 0-abstain/recuse, 1-absent
MOTION FAILED.

FORMAL INTERVIEWS (Continued) - JASON J. WOO, M.D.

MOTION: Patrick N. Connell, M.D., moved to issue an Advisory Letter for the attempted use of forceps and failing to proceed to C-Section causing the death of an infant, mitigated by system problems.
SECONDED: Chris Wertheim
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
6.	MD-03-0458A	AMB	BRENT C. SANDERS, M.D.	6754	Continuance granted; formal interview will be rescheduled at the August 2004 Board meeting.

Brent C. Sanders, M.D., appeared before the Board with his attorney Kimberly Kent. Ms. Kent asked the Board for a continuance due to time constraints. Edward J. Schwager, M.D., granted her request.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
4.	MD-03-0310A	N.M.	L. ALFONSO MUNOZ, M.D.	9794	Advisory Letter for failing to inform the patient of a pathology report. A.R.S. § 32-1401(3)(b) – The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

L. Alfonso Munoz, M.D., appeared before the Board with his attorney John Black.

William Kennell, M.D., Board Medical Consultant, reviewed this case with the Board. The allegation is that Dr. Munoz failed to inform the patient of the high suspicion for adenocarcinoma, following an esophagogastroduodenoscopy and biopsy and failed to arrange for repeat biopsy and/or further follow-up.

Dr. Munoz made a statement to the Board. He stated that there were multiple diagnoses for this patient. Dr. Munoz stated that he indicated possible inflammation or cancer. Dr. Munoz was concerned about an ulcer that had the possibility of perforation or bleeding, because it was deep and recommended that the patient be admitted to the hospital. His long-term concern was to perform a biopsy at a later date. The patient was reluctant, so Dr. Munoz scheduled him to return as soon as possible. Dr. Munoz explained all of the diagnoses to the patient. On a later office visit, the patient was stable and had not developed the complications that Dr. Munoz was concerned about. When Dr. Munoz received the report from the pathologist that indicated a nodule in the stomach and immediate action was taken. Dr. Munoz sent the patient a copy of the report and asked his office staff to contact the patient for an office visit to discuss the possibility of a neoplasm. At that visit, Dr. Munoz stated that another appointment was made for an endoscopy, but the patient called back and canceled his appointment. Dr. Munoz was unaware of this cancellation.

William R. Martin, III, M.D., presenting Board member, began the questioning of Dr. Munoz. Dr. Munoz confirmed that gastroesophagel adenocarcinoma is a fast growing tumor and the national history is dismal, despite surgery. The survival rate is approximately five-years. Dr. Martin asked if the information was relayed to the patient of the seriousness of the situation. Dr. Munoz stated that he asked the patient to come in for an office visit. Dr. Martin asked if the patient was cognitive. Dr. Munoz said he did not have enough information to make that conclusion. Dr. Munoz stated he was not aware, at the time, that the patient cancelled his appointment, because no one informed him. Dr. Munoz stated that he did not fall below the standard of care, because the institution did not inform him that the patient cancelled is appointment. The Board members questioned Dr. Munoz. Dr. Krishna had Dr. Munoz review his training.

Dr. Munoz made a statement to the Board. He stated that some of his notes were not as extensive as they should have been. He would like the opportunity to explain what happened to the patient's family.

Mr. Black made a statement to the Board on behalf of Dr. Munoz. Mr. Black stated that Dr. Munoz informed the patient, but the patient refused to follow up with the two consultants that Dr. Crutchfield referred him to. Regarding the cancellation, Banner Health had recognized there was a systemic problem, but that is now corrected, because of the recognition that a physician would not be able to remember to follow up without being reminded.

Dr. Martin stated that there are a number of factors involved in this case. Was the patient appropriately informed about his diagnosis? The physician indicates that he informed the patient three times, but did not document that in the records. The wife of the patient adamantly stated that the diagnosis was never given to them. Dr. Martin stated that the mitigating factors involved are that there were other diagnoses, which was where the focus of care was. Also, the patient had no gastro intestinal (G.I.) discomfort with his initial visit. Dr. Martin stated that Dr. Munoz's records are not clear regarding discussions with the patient of the results. The harm was that the patient was not given the opportunity to get his affairs in order and was not able to maintain their home. The standard of care would be that physicians are expected to have adequate notes that a diagnosis has been conveyed to a patient with follow up. Dr. Martin recommended a finding of unprofessional conduct in violation of A.R.S. § 32-1401(26)(q) – Any conduct or practice that is or might be harmful or dangerous to the health of the

patient or the public. Edward J. Schwager, M.D., suggested that there was a combination of lack of communication and record keeping. Dr. Schwager stated that the physician's records or well organized, although it would be ideal if the diagnosis and follow up were recorded.

Dr. Kennell suggested that the patient might have kept the diagnosis to himself. Ingrid E. Haas, M.D., stated that the record does indicate that information was sent to the attending physician and that physician intended to follow up with the patient. Dr. Schwager stated that patient's also have a responsibility to follow up.

MOTION: William R. Martin, III, M.D., moved for a finding unprofessional conduct in violation of A.R.S. § 32-1401(26)(q) – Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ram R. Krishna, M.D.
VOTE: 7-yay, 2-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

William R. Martin, III, M.D., stated that this does not rise to the level of discipline, because of the mitigating factors involved earlier. Dr. Martin recommended issuing an Advisory Letter for failure to properly inform the patient of a pathology diagnosis and is a minor or technical violation.

MOTION: William R. Martin, III, M.D., moved to issue an Advisory Letter for failing to inform the patient of a pathology diagnosis. A.R.S. § 32-1401(3)(b) – The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Becky Jordan
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., and Chris Wertheim The following Board members voted against the motion: Ingrid E. Haas, M.D. and Edward J. Schwager, M.D. The following Board members were absent when this matter was considered: Douglas D. Lee, M.D. and Sharon B. Megdal, Ph.D. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 7-yay, 2-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
5.	MD-03-0300A	K.M.	STEPHEN W. HARTZ, M.D.	12105	Dismissed.

Stephen W. Hartz, M.D., appeared before the Board without legal representation.

Rudolf Kirschner, M.D., Board Medical Consultant, reviewed this case with the Board. The allegations are that Dr. Hartz misdiagnosed the patient with rheumatic fever, and failed to order the appropriate diagnostic tests to confirm this diagnosis (ie: Strep culture, blood cultersX3, etc). Also, that Dr. Hartz subsequently altered the medical record to reflect the correct diagnosis of strep throat and influenza.

Dr. Hartz made a statement to the Board. Dr. Hartz referred to a medical sheet with his notes on it. He stated that it was his understanding that these were used primarily for note taking and not to submit to an insurance company. He would submit his dictations for that purpose of billing the insurance companies. The insurance company contacted the patient's mother and one of Dr. Hartz's colleagues and informed them that there was a problem with the diagnosis, so when he found out, he made the corrections. His "notes" were his process of ruling certain diagnoses out or other diagnoses that concerned about and was not to be used for insurance purposes.

Dona Pardo, Ph.D., R.N., presenting Board member, began the questioning of Dr. Hartz. Dr. Hartz stated that he ordered antibiotics for this patient, because he felt it would protect the patient's heart from further damage. Other tests were not ordered because it was an emergency room (E.R.) situation in terms of getting the patient facilitated. Dr. Hartz explained the symptoms the patient was having, which was why he diagnosed Rheumatic Fever. She asked why there was such a long period between the actual examination and the dictation time. Dr. Hartz stated that his brother had been sick and he would fly to Houston to visit him before he passed away, which delayed his dictations. In the interim, his notes and report were apparently sent to the insurance company. He changed the diagnosis for this patient at the request of the Director of Medical Records, because the insurance company insisted on it. The Board members began questioning Dr. Hartz. Robert P. Goldfarb, M.D., asked Dr. Hartz how he remembers the various patients if he dictates days later. Dr. Hartz explained that he reviews pertinent information from his notes. Dr. Hartz stated that the physicians are required to have their dictations done within 72 hours.

FORMAL INTERVIEWS (Continued) - STEPHEN W. HARTZ, M.D.
Dr. Hartz made a statement before the Board that he has been practicing for twenty years and he has never been before the Board.

Dr. Pardo referred to the physician Board members for a recommendation. William R. Martin, III, M.D., stated that it is not unusual to simply cross something out and initial it.

MOTION: William R. Martin, III, M.D., moved to dismiss this case
SECONDED: Becky Jordan

Dr. Schwager stated that this case appears somewhat sloppy, but not harmful. The change was made to the handwritten E.R. note dated after the dictation. The change was needed for consistency. There is not enough information here for disciplinary action or even an advisory letter.

ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Edward J. Schwager, M.D., and Chris Wertheim The following Board members were absent when this matter was considered: Douglas D. Lee, M.D. and Sharon B. Megdal, Ph.D. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3 absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
7.	MD-02-0823A	AMB	JEFFREY M. TAFFET, M.D.	16326	Advisory Letter for premature discharge of an infant with sleep apnea from the PACU. A.R.S. § 32-1401(3)(b) – The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
	MD-02-0823B		TODD SMITH, M.D.	26498	

MD-02-0823A – Jeffery M. Taffet, M.D.
Jeffrey M. Taffet, M.D., appeared before the Board with his attorney Duane A. Olson.

Philip Scheerer, M.D., Board Medical Consultant, reviewed this case with the Board. The allegations are that Dr. Taffet negligently performed an adenotonsillectomy on a two-year old child with obstructive sleep apnea in an outpatient setting. Also, Dr. Taffet improperly allowed premature discharge of two-year-old child with obstructive sleep apnea following adenotonsillectomy, rather than observing him in a hospital setting.

Dr. Taffet made a statement to the Board. Dr. Taffet reviewed the Staff Investigational Review Committee (SIRC) report with the Board members and the Outside Medical Consultant's (OMC) conclusions.

Robert P. Goldfarb, M.D., presenting Board member, began the questioning of Dr. Taffet. Dr. Taffet stated that surgery would normally cure the problem of sleep apnea. All children with this condition are discharged on an individual basis. At the time this surgery took place, sleep apnea children were discharged home. Dr. Taffet stated that the standard of care is now different then what it was at the time of the surgery. Dr. Goldfarb asked if he fell below the standard of care. Dr. Taffet stated that four years ago, he did not. He stated that the trend in sleep study, including apnea, was that there had been a sliding scale, because these are not black and white cases. He gave an example to the Board of the variables.

Mr. Olson made a statement to the Board on behalf of Dr. Taffet. He stated that Dr. Taffet has done over 9000 procedures, without any significant complications. Mr. Olson consulted with Peter Nutley, M.D., who is an ENT specialist regarding this case. Dr. Nutley confirmed that the care of this patient met the standard of care and that no deviation could be identified. These types of procedures were performed in freestanding facilities. There were also other issues that were involved with this child. He stated that an Advisory Letter would be appropriate. Dr. Taffet's record is good, regarding the care of his patients over the last seventeen years.

MD-02-0823B – Todd Smith, M.D.
Todd Smith, M.D., appeared before the Board with his attorney Judith Berman.

Philip Scheerer, M.D., Board Medical Consultant, reviewed this case with the Board. The allegations are that Dr. Smith negligently discharged a two-year-old child with a history of sleep apnea, two hours post-tonsillectomy and adenoidectomy. Also, Dr. Smith negligently administered anesthesia and analgesia in improper amounts to a two-year-old child.

Dr. Smith made a statement to the Board. Dr. Smith stated that he discovered Ear, Nose, ant Throat (ENT) literature regarding guidelines, after becoming aware of this case. The guidelines came out only six months after this case occurred. He stated that it is very unlikely that the child's demise was a result of airway occlusion caused by improper head positioning.

FORMAL INTERVIEWS (Continued) - JEFFREY M. TAFFET, M.D. & TODD SMITH, M.D.

When the patient was taken home, the child was left with a family friend, who fell asleep while he was holding the child. The child was found dead. Dr. Smith addressed the discharge of the patient and stated that the nurses have the authority to discharge a patient.

Robert P. Goldfarb, M.D., presenting Board member began the questioning of Dr. Smith. Dr. Goldfarb asked if he takes any precautions postoperatively after the patient goes to the recovery room when there is a history of sleep apnea. Dr. Smith stated that the complications in post-op are very rare; typically he will administer a small amount of Morphine or Demerol. This patient was extremely combative and crying, which is why he was medicated. Dr. Smith stated that if he could do this all over again, he would have evaluated the patient personally instead of trusting the nurse. The Board members began questioning Dr. Smith. The Board member clarified that the physicians do not need to sign off for a patient's discharge.

Ms. Berman made a statement to the Board on behalf of Dr. Smith. She suggested that this case be dismissed, or issue an Advisory Letter. She stated that Dr. Smith had an opportunity to see the child in post-op and the child looked stable at that time. Also, the discharge criteria of Scottsdale Osborne, allows nurses to discharge, without the physicians approval. Dr. Smith indicated that the morphine given was within the standard of care.

MD-02-0823A – Jeffery M. Taffet, M.D. & MD-02-0823B – Todd Smith, M.D.

Dr. Goldfarb stated that this was a terrible case. Surgery is a team and people have to work together, especially the surgeon and the anesthesiologist. Unless the physicians work together as a team, the outcome will not be what they are looking for. If a physician has a patient with sleep apnea, there should be a red flag that this would not be an average T and A. Dr. Goldfarb noted that Osborn Ambulatory Surgery Center does have certain rules for discharge, but they are not rules for sleep apnea patients. Dr. Goldfarb stated there has been unprofessional conduct of the premature discharge of the patient from the ambulatory surgery unit within one hour of the surgery in violation of A.R.S. § 32-1401(26)(q) -) – Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public. There was potential harm because there may have been some additional circumstances, which occurred after the patient left the ambulatory surgical center. Dr. Schwager clarified that the potential harm was the premature discharge resulting in respiratory distress and possible death. Dr. Schwager also clarified that the circumstances of this case caused the death of the patient. Dr. Krishna commented that discharge policies are not blanket policies for everyone and that each case should be determined individually.

MOTION: Robert P. Goldfarb, M.D., moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(26)(q) -) – Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public, for the premature discharge of the patient from the ambulatory surgery unit within one hour of the surgery.
SECONDED: Ram R. Krishna, M.D.
VOTE: 8-yay, 1-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

MOTION: Robert P. Goldfarb, M.D., moved to issue an Advisory Letter for the premature discharge of an infant with sleep apnea from the PACU. A.R.S. § 32-1401(3)(b) – The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE was taken and the following Board members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., and Chris Wertheim. The following Board member voted against the motion: Edward J. Schwager, M.D. The following Board members were not present when this matter was discussed: Douglas D. Lee, M.D. and Sharon B. Megdal, Ph.D. The following Board member was absent from the meeting: Tim B. Hunter, M.D.
VOTE: 8-yay, 1-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

RECOMMENDATION FOR NON-DISCIPLINARY ACTION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-03-0571A	G.A.	ROBERT J. ALLEN, M.D.	13801	Dismissed.

Robert J. Allen, M.D., made a statement at the call to the public. He wanted to clarify information about some of the letters submitted to the Board. He asked that the Board withdraw the advisory letter.

Ram R. Krishna, M.D., stated that the physician is not a fault. He recommended that this case be dismissed.

MOTION: Ram R. Krishna, M.D., moved to dismiss this case.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

RECOMMENDATION FOR NON-DISCIPLINARY ACTION (Continued) - EDWARD BYRNE-QUINN, M.D.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
2.	MD-03-0793A	L.H.	EDWARD BYRNE-QUINN, M.D.	6724	Advisory Letter for dispensing unlabeled medications.

Edward J. Schwager, M.D., recused himself from this matter. Robert P. Goldfarb, M.D., knows Dr. Byrne-Quinn, but that will not affect his ability to adjudicate this case.

MOTION: Ram R. Krishna, M.D., moved to issue an Advisory Letter for dispensing unlabeled medications.
SECONDED: William R. Martin, III, M.D.
VOTE: 8-yay, 0-nay, 1-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
3.	MD-03-0545B	T.V.	THOMAS VORPAHL, M.D.	10588	Advisory Letter for failure to diagnose neural tissue in biopsy of the left nasal sinus.

Attorney Richard Rea made a statement at the call to the public on behalf of Thomas Vorpahl, M.D. He stated that Dr. Vorpahl does not have any previous action against him. He performs above the standard of care. The Investigators report did not identify any conduct that was dangerous or harmful. The issue of this investigation does not include conduct or practices this case should be dismissed.

Dr. Vorpahl made a statement at the call to the public. He stated that the patient was a 50-year-old person for routine sinus surgery, endoscopic, because of sinusitis. The cranial cavity had been entered during the surgery. Clinical information was not conveyed to him. He has never seen a case of brain material in the sinuses. His examination did follow the standard of care and fully described his findings. This is an extremely rare event. The pathologists depend on accurate and detailed information to make correct findings. There are quality assurance programs in place that continue to be improved. Anything in questions would be reviewed. The reports describe everything in detail.

MOTION: Ram R. Krishna, M.D., moved to issue an Advisory Letter for failure to diagnose neural tissue in biopsy of the left nasal sinus.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
4.	MD-03-0713A	B.F.	ERIK WOMELDORF, M.D.	24343	Advisory Letter for failure to adequately evaluate and treat post-concussion symptoms.

Attorney Ed Gaines made a statement at the call to the public on behalf of Erik Womeldorf, M.D. He stated that Dr. Womeldorf has recognized that he should have done things differently. He has learned from this.

Dr. Womeldorf made a statement at the call to the public. He regrets not ordering the imaging sooner for this case. He has changed his practice.

Robert P. Goldfarb, M.D., stated that this was a case of subduralhematoma that was missed by the physician and supports an Advisory Letter. Patrick N. Connell, M.D., also agreed.

MOTION: Patrick N. Connell, M.D., moved to issue an Advisory Letter for failure to adequately evaluate and treat post-concussion symptoms.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
5.	MD-03-0689B	G.M.	KHRISTINA MARIA RAMIREZ, M.D.	30564	Dismissed.

Khristina M. Ramirez, M.D., made a statement at the call to the public. She stated that she was not the supervising physician of the Physician Assistants (P.A.). They do not present every case to her for review. She saw the patient on 5/6 and diagnosed mild bronchialitis. She saw the child on June 2, 2003 for a well child check up. She was not there when the results came in. She stated that she is a good physician and does not want her record tainted with something that was not under her control. She is diligent with her follow up.

RECOMMENDATION FOR NON-DISCIPLINARY ACTION (Continued) - KHRISTINA MARIA RAMIREZ, M.D.
Ram R. Krishna, M.D., recommended that this case be dismissed because of the statement made this morning that Dr. Ramirez was not the supervising physician.

MOTION: Ram R. Krishna, M.D., moved to dismiss this case.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
6.	MD-03-0935A	AMB	SHAWN ANTHONY TASSONE, M.D.	29157	Invite Dr. Tassone for a formal interview before the Board.

Ram R. Krishna, M.D., stated that this case warrants more than an advisory letter because it involved a physician that was prescribing over the Internet, without a physical examination of the patients. Patrick N. Connell, M.D., agreed. Dr. Connell stated that the physician, in his response to the Board, made the statement that he was prescribing harmless prescriptions, but Retin-A is known to have severe affects if prescribed to the wrong patient. Edward J. Schwager, M.D., stated that he would not prescribe Retin-A to a woman who is pregnant, but agreed with the Staff Investigational Review Committee (SIRC) recommendation for an Advisory Letter. This case is different than the other cases brought before the Board with Internet prescribing.

MOTION: Ram R. Krishna, M.D., moved to invite this physician for a formal interview before the Board.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 8-yay, 1-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
7.	MD-03-1090A	AMB	SHERWOOD K. DUHON, M.D.	20868	Advisory Letter for failure to diagnose a Monteggia fracture in a 6-year-old patient. A.R.S. § 32-1401(3)(b) - The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

MOTION: William R. Martin, III, M.D., moved to issue an Advisory Letter for failure to diagnose a Monteggia fracture in a 6-year-old patient. A.R.S. § 32-1401(3)(b) - The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

Ram R. Krishna, M.D., recommended that Board staff investigate the radiologist in this case. He stated that the records indicate that the radiologist failed to recognize the fracture also. There is potential harm to the patient. Edward J. Schwager, M.D., stated that in Dr. Stamps report, she indicates that this would be a difficult diagnosis to make. Dr. Krishna stated that it would be an easy fracture to recognize.

MOTION: Ram R. Krishna, M.D., moved to direct Board staff to investigate the radiologist in this case.
SECONDED: William R. Martin, III, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
8.	MD-03-1293A	AMB	PEGGY AVINA, M.D.	25622	Advisory Letter for failure to appreciate the severity of the fracture of the thoracic spine. A.R.S. § 32-1401(3)(b) - The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Peggy Avina, M.D., made a statement at the call to the public. She stated that the patient could move his extremities, but would not. His major complaint was abdominal pain and later voiced back pain. She palpated his spine, which was tender. The Computerized Tomography Scan (CT) scan was read by a second radiologist and recommended a CT of the patient's spine. The patient fully recovered except for foot drop. She performed repeated examinations, but was it documented in a summary fashion.

Robert P. Goldfarb, M.D., stated that this was a bad fracture. Also, the patient was very hostile and there was a systems problem. However, this does warrant an Advisory Letter, because the seriousness of the fracture.

RECOMMENDATION FOR NON-DISCIPLINARY ACTION (Continued) - PEGGY AVINA, M.D.

MOTION: Ram R. Krishna, M.D., moved to issue an Advisory Letter for failure to appreciate the severity of the fracture of the thoracic spine. A.R.S. § 32-1401(3)(b) - The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Patrick N. Connell, M.D.
VOTE: 8-yay, 1-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
9.	MD-03-0055A	AMB	NICHOLAS JAMES SOLDO, M.D.	8166	Dismissed.

Attorney Steven Myers made a statement at the call to the public on behalf of Dr. Soldo. Mr. Myers reviewed the reasons why Dr. Soldo used Restylane for wrinkles before it was FDA approved. Mr. Myers stated that Dr. Soldo, out of respect for the Board, ceased using Restylane until it was FDA approved or the resolution of this case. Mr. Myers referred to cases with the United States Court of Appeals and the Board's history with these types of cases.

Ingrid E. Haas, M.D., recused herself from this matter. Ram R. Krishna, M.D., state that utilizing medications that are not FDA approved on or off label is a deviation from the standard of care. Dr. Krishna would support an Advisory Letter. Edward J. Schwager, M.D., spoke against an Advisory Letter and would support dismissal. The medical records indicate a consent that was signed and recognized by the patient that the prescriptions were not FDA approved. There is evidence of materials being used off-label.

MOTION: Patrick N. Connell, M.D., moved to dismiss this case.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 7-yay, 0-nay, 2-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
10.	MD-03-0338A	J.S.	STEPHEN EUGENE FLYNN, M.D.	3351	Advisory Letter for failure to maintain adequate medical records. A.R.S. § 32-1401(3)(b) - The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

MOTION: Edward J. Schwager, M.D., moved to issue an Advisory Letter for failure to maintain adequate medical records. A.R.S. § 32-1401(3)(b) - The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
11.	MD-03-0131A	AMB	JOSE ANTONIO CARRION, M.D.	14604	Advisory Letter for failure to identify the presence of a lesion on the CT scan of the brain. A.R.S. § 32-1401(3)(b) - The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Robert P. Goldfarb, M.D., stated that this is a case that resulted in the blindness of a ten-year old. Edward J. Schwager, M.D., noted the mitigation as stated in the Staff Investigational Review Committee (SIRC) report.

MOTION: Robert P. Goldfarb, M.D., moved to issue an Advisory Letter for failure to identify the presence of a lesion on the CT scan of the brain. A.R.S. § 32-1401(3)(b) - The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
12.	MD-03-1065A	J.V.	MICHAEL CASTRO, M.D.	23581	Dismissed.

Attorney Gordon Lewis made a statement at the call to the public on behalf of Michael Castro, M.D. He stated this appears to be a case of the mistaken identity. This patient was not a patient of Dr. Castro's. The other physician who saw this patient is

RECOMMENDATION FOR NON-DISCIPLINARY ACTION (Continued) - MICHAEL CASTRO, M.D.
responsible for this patient. All the records indicate this. Dr. Castro, for the release of another practitioner's records, should not be subject to an Advisory Letter. Dr. Castro asked that the Board dismiss this case against him.

Ram R. Krishna, M.D., recommended that this case be dismissed based on the information.

MOTION: Ram R. Krishna, M.D., moved to dismiss this case.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
13.	MD-03-0460A	A.F.	JOSEPH P. AIELLO, M.D.	15612	Advisory Letter for inadequate office staff communication resulting in failure to follow-up with the patient. A.R.S. § 32-1401(3)(a) - While there is insufficient evidence to support disciplinary action, the Board believes that continuation of the activities that led to the investigation may result in further Board action against the licensee.

Attorney Peter Wittekind made a statement at the call to the public on behalf of Joseph P. Aiello, M.D. He stated that Dr. Aiello saw a 58-year-old patient with dry eye syndrome. He stated that this case was originally dismissed by the Executive Director, but was returned as an Advisory Letter at the Board's request. He stated this case should be dismissed. The complainant called after hours and there is no record of that call. He asked that the Board dismiss this case.

Dr. Aiello made a statement at the call to the public. He stated that the care of this patient was appropriate. The patient understood the procedure and if there were any difficulties and informed him to see him.

MOTION: Ram R. Krishna, M.D., moved to issue an Advisory Letter for inadequate office staff communication resulting in failure to follow-up with the patient. A.R.S. § 32-1401(3)(a) - While there is insufficient evidence to support disciplinary action, the Board believes that continuation of the activities that led to the investigation may result in further Board action against the licensee.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
14.	MD-03-0782A	S.W.	MURALI D. TALLURI, M.D.	19237	Advisory Letter for the administration of Nubain to a patient with a history of opiod dependence.

MOTION: Ram R. Krishna, M.D., moved to issue and Advisory Letter for the administration of Nubain to a patient with a history of opiod dependence.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
15.	MD-04-0081A	AMB	W. NEIL CHLOUPEK, M.D.	4553	Referred to Formal Hearing.

Stephen Wolf, Assistant Attorney General, made a statement at the call to the public. The state requests that this case be referred to Formal Hearing instead of issuing an Advisory Letter. This will be for consideration with a companion case. He reviewed the details of Dr. Chloupek's Summary Suspension with the Board. Mr. Wolf stated that Dr. Chloupek had prescribed a drug of choice for another physician telephonically without a physician examination or the attempt to determine the physician's recovery status. The State believes that these cases should be considered together.

MOTION: Patrick N. Connell, M.D., moved to refer this case to Formal Hearing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

The meeting adjourned at 6:59 p.m.
[Seal]

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Barry A. Cassidy, Ph.D., P.A.-C, Executive Director